STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	1029 EAST 5TH STREET CONNERSVILLE, IN47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00085926. Complaint IN00085926 - Substantiated, federal/state deficiencies related to the allegations are cited at F223, F225, F226 and F281. Survey dates: February 23, and 24, 2011 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Survey team: Barbara Gray RN Census bed type: SNF/NF: 104 Total: 104 Census payor type: Medicare: 13 Medicaid: 80 Other: 11 Total: 104	F0000	Preparation or execution of this plan of correction (POC) does not constitute an admission or assent by the provider to the truth, accuracy or veracity or the alleged or conclusions set forth in the Statement of Deficiencies (SOD). The POC is prepared and executed solely because it is required under law. Lincoln Centers for Rehabilitation and Healthcare acknowledges receipt of the SOD and alleges that it is in compliance. Accordingly, the POC is submitted as alleged compliance as of March 25, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 3 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3/1/11 by Jennie Bartelt, RN.			

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F0223 SS=D	Based on observation, interview, and record review, the facility failed to ensure the resident was free of physical abuse, in that the resident was catheterized by a nurse alleged to be impaired for 1 of 3 residents reviewed related to allegations of abuse in a sample of 3. (Resident #A) Findings include: Resident #A was observed lying in bed on 2/23/11 at 3:48 P.M. Resident #A had facial features of Down's Syndrome and was non-responsive when spoken to. Resident #A's record was reviewed on 2/23/11 at 11:10 A.M. Diagnoses included, but were not limited to, Down's Syndrome and mental retardation. Resident #A's significant change Minimum Data Set assessment, dated 1/18/11, indicated Resident #A had unclear speech, rarely/never	F0223	**F 223 SS: D Free From Abuse/Involuntary Seclusion** It is the policy of this facility to comply with regulatory requirement Free From Abuse/Involuntary Seclusion. 1.) Resident A was re-assessed by Social Services and appropriate actions were taken at the time. Disciplinary action of staff was also completed as appropriate at time. 2.) Facility has conducted a review of a random sample of charts and resident interviews to ensure residents have remained free from Abuse. 3.) Staff has been re-educated on the facility policy and procedure related to abuse prevention, reportable occurrences and drug testing policy. DON/SSD or designee will QA monitor abuse through random alert and oriented interviewable resident interviews daily excluding weekends and holidays x 4 weeks, weekly x 4 weeks, then monthly x 2 months. 4. Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations acted on as indicated. 5.) Allegation of Compliance: March 25, 2011.	03/25/2011

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	understood others, was rarely/never understood, required extensive assistance of two persons for bed mobility, required total dependence on 2 persons to transfer, did not walk, required total dependence on 2 persons to dress, required total dependence on 2 persons to toilet, and was always incontinent of bowel and bladder. A copy of an incident on 2/7/11 at 9:30 P.M., provided by the Director of Nursing on 2/23/11 at 1:30 P.M., indicated the following facility investigation: Description of Incident - The Director of Nursing (DoN) received a call from confidential staff #1, indicating LPN #2 appeared impaired. The DoN arrived at the East facility building, and obtained a urine drug screen from LPN #2. The drug screen did not reach the required temperature range on the temperature strip. The DoN requested LPN #2 drink something in order to provide another urine			

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	sample. While waiting on LPN #2, the DoN received a message from confidential staff #3, indicating LPN #2 had catheterized Resident #A in order to obtain a urine sample. Approximately 20 minutes later, LPN #2 reported to the DoN to provide another urine sample. When LPN #2 provided the DoN her urine sample, the DoN questioned LPN #2 about the possibility the urine sample was actually obtained from Resident #A. At first LPN #2 denied the allegation, then finally admitted the allegation was true, stating she "knew it was wrong and didn't know what else to do". The DoN informed LPN #2 to count off her narcotic medications and gather her belongings to leave. The DoN remained with LPN #2 until she left the building. Type of injury/injuries - The resident was assessed, and no redness, discoloration, or edema present. The resident showed no change in mood or behavior. Immediate			

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	action taken - LPN #2 was escorted out of the building by the DoN. Preventative measures taken - The MD was updated. The resident had no responsible party to notify. LPN #2 was terminated. LPN #2 would be reported to the Professional Licensing Board. The first urine drug screen from LPN #2 would be sent for laboratory testing. Resident #A would continue to be monitored for signs and symptoms of a urinary tract infection, and changes in mood or behavior, and staff would be re-educated on the facility's abuse and drug testing policy. An interview with the DoN on 2/23/11 at 1:50 P.M., indicated when she arrived at the East facility building the evening of 2/7/11, she met with LPN #2 in the conference room and provided her with a urine drug screen cup. The urine drug screen provided by LPN #2 did not reach the required temperate on the temperature strip. She gave LPN			

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	#2 a dollar, and requested she get something to drink, to help her urinate. The DoN indicated LPN #2 also wanted to smoke. The DoN went to the West facility building to obtain another urine drug screen. The DoN returned to the East facility building conference room and waited on LPN #2 to return, and provide another drug screen. While the DoN waited on LPN #2 to return to the conference room she received a text message from confidential staff #3, LPN #2 had catheterized Resident #A to obtain a urine sample. LPN #2 returned to the conference room, took the urine drug screen from the DoN, went to the bathroom and returned with a urine sample. After several minutes of conversation, LPN #2 admitted she had straight catheterized Resident #A to use for her urine drug screen. The most current abuse policy provided by the Administrator on 2/23/11 at 10:30 A.M., indicated			

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	the following: Overview - The facility has implemented processes that include the seven components of abuse prevention and management: screening, training, prevention, identification, protection, investigation, and reporting... Prevention - 1.) Ensure that prevention techniques are implemented in the facility including, but not limited to : Ongoing supervision of employees through visual observation of care delivery... 2.) Identify, correct, and intervene in situations where abuse, neglect, and/or mistreatment are most likely to occur... Protection - 1.) Provide for the immediate safety of the resident/patient upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property.... This federal tag is related to Complaint IN00085926. 3.1-27(a)(1)			

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F0225 SS=D	Based on observation, interview, and record review, the facility failed to protect residents from abuse by a nurse alleged to be working impaired during investigation of the allegation. The deficient practice affected 1 of 3 residents reviewed related to the allegation of abuse in a sample of 3. (Resident #A). Findings include: Resident #A was observed lying in bed on 2/23/11 at 3:48 P.M. Resident #A had Down's Syndrome facial features, and was non-responsive when spoken to. Resident #A's record was reviewed on 2/23/11 at 11:10 A.M. Diagnoses included, but were not limited to, Down's Syndrome and mental retardation. Resident #A's significant change Minimum Data Set assessment, dated 1/18/11, indicated Resident #A had unclear speech, rarely/never understood others, was rarely/never understood, required extensive assistance of two persons for bed mobility, required total dependence on 2 persons to transfer, did not walk, required total dependence on 2 persons to dress, required total dependence on 2 persons to toilet, and was always incontinent of bowel and	F0225	**F 225 SS: D Investigate/Report Allegations/Individuals** It is the policy of this facility to comply with Investigating and Reporting Allegations. 1.) Resident A was re-assessed by Social Services and appropriate actions were taken at the time. Disciplinary action of staff was also completed as appropriate at time. 2.) Facility has conducted a review of a random sample of charts and resident interviews to ensure residents have remained free from Abuse. 3.) Staff has been re-educated on the facility policy and procedure related to abuse prevention, reportable occurrences and drug testing policy. DON/SSD or designee will QA monitor abuse through random alert and oriented interviewable resident interviews daily excluding weekends and holidays x 4 weeks, weekly x 4 weeks, then monthly x 2 months. 4. Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations acted on as indicated. 5.) Allegation of Compliance: March 25, 2011.	03/25/2011

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	bladder. A copy of an incident on 2/7/11 at 9:30 P.M., provided by the Director of Nursing on 2/23/11 at 1:30 P.M. indicated the following facility investigation: Description of Incident - The Director of Nursing (DoN) received a call from confidential staff #1, indicating LPN #2 appeared impaired. The DoN arrived at the East facility building, and obtained a urine drug screen from LPN #2. The drug screen did not reach the required temperature range on the temperature strip. The DoN requested LPN #2 drink something in order to provide another urine sample. While waiting on LPN #2, the DoN received a message from confidential staff #3, indicating LPN #2 had catheterized Resident #A in order to obtain a urine sample. Approximately 20 minutes later, LPN #2 reported to the DoN to provide another urine sample. When LPN #2 provided the DoN her urine sample, the DoN questioned LPN #2 about the possibility the urine sample was actually obtained from Resident #A. At first LPN #2 denied the allegation, then finally admitted the allegation was true, stating she "knew it was wrong and didn't know what else to do". The DoN informed LPN #2 to count off her narcotic medications and gather her belongings to			

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	leave. The DoN remained with LPN #2 until she left the building. Type of injury/injuries - The resident was assessed, and no redness, discoloration, or edema present. The resident showed no change in mood or behavior. Immediate action taken - LPN #2 was escorted out of the building by the DoN. Preventative measures taken - The MD was updated. The resident had no responsible party to notify. LPN #2 was terminated. LPN #2 would be reported to the Professional Licensing Board. The first urine drug screen from LPN #2 would be sent for laboratory testing. Resident #A would continue to be monitored for signs and symptoms of a urinary tract infection, and changes in mood or behavior, and staff would be re-educated on the facility's abuse and drug testing policy. An interview with the DoN on 2/23/11 at 1:50 P.M., indicated when she arrived at the East facility building the evening of 2/7/11, she met with LPN #2 in the conference room and provided her with a urine drug screen cup. The urine drug screen provided by LPN #2 did not reach the required temperate on the temperature strip. She gave LPN #2 a dollar, and requested she get something to drink, to help her urinate. The DoN indicated LPN #2 also wanted to smoke. The DoN went			

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	to the West facility building to obtain another urine drug screen. The DoN returned to the East facility building conference room and waited on LPN #2 to return, and provide another drug screen. While the DoN waited on LPN #2 to return to the conference room she received a text message from confidential staff #3, LPN #2 had catheterized resident #A to obtain a urine sample. LPN #2 returned to the conference room, took the urine drug screen from the DoN, went to the bathroom and returned with a urine sample. After several minutes of conversation, LPN #2 admitted she had straight catheterized Resident #A to use for her urine drug screen. An interview with the DoN on 2/24/11 at 10:00 A.M., indicated she should have stayed with LPN #2 until she provided the second urine drug screen. The DoN indicated LPN #2 needed to get something to drink, and wanted to smoke, and that is what she thought LPN #2 would be doing while she went to the West building to get another drug screen. The most current abuse policy provided by the Administrator on 2/23/11 at 10:30 A.M., indicated the following: Overview - The facility has implemented processes that include the seven components of			

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	abuse prevention and management: screening, training, prevention, identification, protection, investigation, and reporting... Prevention - 1.) Ensure that prevention techniques are implemented in the facility including, but not limited to : Ongoing supervision of employees through visual observation of care delivery... 2.) Identify, correct, and intervene in situations where abuse, neglect, and/or mistreatment are most likely to occur... Protection - 1.) Provide for the immediate safety of the resident/patient upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property.... This federal tag is related to Complaint IN00085926. 3.1-28(d)			

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F0226 SS=D	Based on observation, interview, and record review, the facility failed to follow its policy for protecting residents from abuse by a nurse alleged to be working impaired during investigation of the allegation. The deficient practice affected 1 of 3 residents reviewed related to allegations of abuse in a sample of 3. (Resident #A). Findings include: Resident #A was observed lying in bed on 2/23/11 at 3:48 P.M. Resident #A had Down's Syndrome facial features, and was non-responsive when spoken to. Resident #A's record was reviewed on 2/23/11 at 11:10 A.M. Diagnoses included, but were not limited to, Down's Syndrome and mental retardation. Resident #A's significant change Minimum Data Set assessment, dated 1/18/11, indicated Resident #A had unclear speech, rarely/never understood others, was rarely/never understood, required extensive assistance of two persons for bed mobility, required total dependence on 2 persons to transfer, did not walk, required total dependence on 2 persons to dress, required total dependence on 2 persons to toilet, and	F0226	**F 226 SS: D Develop/Implement Abuse/Neglect, etc Policies** It is the policy of this facility to comply with Developing and Implementing Abuse/Neglect, etc Policies.1.) Resident A was re-assessed by Social Services and appropriate actions were taken at the time. Disciplinary action of staff was also completed as appropriate at time. 2.) Facility has conducted a review of a random sample of charts and resident interviews to ensure residents have remained free from Abuse. 3.) Staff has been re-educated on the facility policy and procedure related to abuse prevention, reportable occurrences and drug testing policy. DON/SSD or designee will QA monitor abuse through random alert and oriented interviewable resident interviews daily excluding weekends and holidays x 4 weeks, weekly x 4 weeks, then monthly x 2 months. 4. Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations acted on as indicated. 5.) Allegation of Compliance: March 25, 2011.	03/25/2011

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	was always incontinent of bowel and bladder. A copy of an incident on 2/7/11 at 9:30 P.M., provided by the Director of Nursing on 2/23/11 at 1:30 P.M., indicated the following facility investigation: Description of Incident - The Director of Nursing (DoN) received a call from confidential staff #1, indicating LPN #2 appeared impaired. The DoN arrived at the East facility building, and obtained a urine drug screen from LPN #2. The drug screen did not reach the required temperature range on the temperature strip. The DoN requested LPN #2 drink something in order to provide another urine sample. While waiting on LPN #2, the DoN received a message from confidential staff #3, indicating LPN #2 had catheterized Resident #A in order to obtain a urine sample. Approximately 20 minutes later, LPN #2 reported to the DoN to provide another urine sample. When LPN #2 provided the DoN her urine sample, the DoN questioned LPN #2 about the possibility the urine sample was actually obtained from Resident #A. At first LPN #2 denied the allegation, then finally admitted the allegation was true, stating she "knew it was wrong and didn't know what else to do". The DoN informed LPN #2 to count off her narcotic			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	1029 EAST 5TH STREET CONNERSVILLE, IN47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications and gather her belongings to leave. The DoN remained with LPN #2 until she left the building. Type of injury/injuries - The resident was assessed, and no redness, discoloration, or edema present. The resident showed no change in mood or behavior. Immediate action taken - LPN #2 was escorted out of the building by the DoN. Preventative measures taken - The MD was updated. The resident had no responsible party to notify. LPN #2 was terminated. LPN #2 would be reported to the Professional Licensing Board. The first urine drug screen from LPN #2 would be sent for laboratory testing. Resident #A would continue to be monitored for signs and symptoms of a urinary tract infection, and changes in mood or behavior, and staff would be re-educated on the facility's abuse and drug testing policy. An interview with the DoN on 2/23/11 at 1:50 P.M., indicated when she arrived at the East facility building the evening of 2/7/11, she met with LPN #2 in the conference room and provided her with a urine drug screen cup. The urine drug screen provided by LPN #2 did not reach the required temperate on the temperature strip. She gave LPN #2 a dollar, and requested she get something to drink, to help her urinate. The DoN indicated LPN			

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	#2 also wanted to smoke. The DoN went to the West facility building to obtain another urine drug screen. The DoN returned to the East facility building conference room and waited on LPN #2 to return, and provide another drug screen. While the DoN waited on LPN #2 to return to the conference room she received a text message from confidential staff #3, LPN #2 had catheterized resident #A to obtain a urine sample. LPN #2 returned to the conference room, took the urine drug screen from the DoN, went to the bathroom and returned with a urine sample. After several minutes of conversation, LPN #2 admitted she had straight catheterized Resident #A to use for her urine drug screen. An interview with the DoN on 2/24/11 at 10:00 A.M., indicated she should have stayed with LPN #2 until she provided the second urine drug screen. The DoN indicated LPN #2 needed to get something to drink, and wanted to smoke, and that is what she thought LPN #2 would be doing while she went to the West building to get another drug screen. The most current abuse policy provided by the Administrator on 2/23/11 at 10:30 A.M., indicated the following: Overview - The facility has implemented processes			

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	that include the seven components of abuse prevention and management: screening, training, prevention, identification, protection, investigation, and reporting... Prevention - 1.) Ensure that prevention techniques are implemented in the facility including, but not limited to : Ongoing supervision of employees through visual observation of care delivery... 2.) Identify, correct, and intervene in situations where abuse, neglect, and/or mistreatment are most likely to occur... Protection - 1.) Provide for the immediate safety of the resident/patient upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property.... This federal tag is related to Complaint IN00085926. 3.1-28(a)			

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F0281 SS=D	Based on observation, interview, and record review, the facility failed to ensure the nurse followed ethical practices of the American Nursing Association in providing resident care. The deficient practice affected 1 of 3 residents reviewed related to allegations of abuse in a sample of 3. The nurse catheterized a resident to use the resident's urine for the nurse's own personal urine drug screen. (Resident #A). Findings include: Resident #A was observed lying in bed on 2/23/11 at 3:48 P.M. Resident #A had Down's Syndrome facial features, and was non-responsive when spoken to. Resident #A's record was reviewed on 2/23/11 at 11:10 A.M. Diagnoses included but were not limited to Down's Syndrome and mental retardation. Resident #A's significant change Minimum Data Set assessment, dated 1/18/11, indicated Resident #A had unclear speech, rarely/never understood others, was rarely/never understood, required extensive assistance of two persons for bed mobility, required total dependence on 2 persons to transfer, did not walk, required total dependence on 2	F0281	**F 281 SS: D Services Provided Meet Professional Standards** It is the policy of this facility to comply with Services Provided Meet Professional Standards. 1.) Resident A was re-assessed by Social Services and appropriate actions were taken at the time. Disciplinary action of staff was also completed as appropriate at time. 2.) Facility has conducted a review of a random sample of charts and resident interviews to ensure residents have remained free from Abuse. 3.) Staff has been re-educated on the facility policy and procedure related to abuse prevention, reportable occurrences and drug testing policy. DON/SSD or designee will QA monitor abuse through random alert and oriented interviewable resident interviews daily excluding weekends and holidays x 4 weeks, weekly x 4 weeks, then monthly x 2 months. 4. Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations acted on as indicated. 5.) Allegation of Compliance: March 25, 2011.	03/25/2011

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	persons to dress, required total dependence on 2 persons to toilet, and was always incontinent of bowel and bladder. A copy of an incident on 2/7/11 at 9:30 P.M., provided by the Director of Nursing on 2/23/11 at 1:30 P.M., indicated the following facility investigation: Description of Incident - The Director of Nursing (DoN) received a call from confidential staff #1, indicating LPN #2 appeared impaired. The DoN arrived at the East facility building, and obtained a urine drug screen from LPN #2. The drug screen did not reach the required temperature range on the temperature strip. The DoN requested LPN #2 drink something in order to provide another urine sample. While waiting on LPN #2, the DoN received a message from confidential staff #3, indicating LPN #2 had catheterized Resident #A in order to obtain a urine sample. Approximately 20 minutes later, LPN #2 reported to the DoN to provide another urine sample. When LPN #2 provided the DoN her urine sample, the DoN questioned LPN #2 about the possibility the urine sample was actually obtained from Resident #A. At first LPN #2 denied the allegation, then finally admitted the allegation was true, stating she "knew it was wrong and didn't			

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	know what else to do". The DoN informed LPN #2 to count off her narcotic medications and gather her belongings to leave. The DoN remained with LPN #2 until she left the building. Type of injury/injuries - The resident was assessed, and no redness, discoloration, or edema present. The resident showed no change in mood or behavior. Immediate action taken - LPN #2 was escorted out of the building by the DoN. Preventative measures taken - The MD was updated. The resident had no responsible party to notify. LPN #2 was terminated. LPN #2 would be reported to the Professional Licensing Board. The first urine drug screen from LPN #2 would be sent for laboratory testing. Resident #A would continue to be monitored for signs and symptoms of a urinary tract infection, and changes in mood or behavior, and staff would be re-educated on the facility's abuse and drug testing policy. An interview with the DoN on 2/23/11 at 1:50 P.M., indicated when she arrived at the East facility building the evening of 2/7/11, she met with LPN #2 in the conference room and provided her with a urine drug screen cup. The urine drug screen provided by LPN #2 did not reach the required temperate on the temperature strip. She gave LPN #2 a dollar, and			

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	requested she get something to drink, to help her urinate. The DoN indicated LPN #2 also wanted to smoke. The DoN went to the West facility building to obtain another urine drug screen. The DoN returned to the East facility building conference room and waited on LPN #2 to return, and provide another drug screen. While the DoN waited on LPN #2 to return to the conference room she received a text message from confidential staff #3, indicating LPN #2 had catheterized Resident #A to obtain a urine sample. LPN #2 returned to the conference room, took the urine drug screen from the DoN, went to the bathroom and returned with a urine sample. After several minutes of conversation, LPN #2 admitted she had straight catheterized Resident #A to use for her urine drug screen. An interview with the DoN on 2/24/11 at 10:00 A.M., indicated she should have stayed with LPN #2 until she provided the second urine drug screen. The DoN indicated LPN #2 needed to get something to drink, and wanted to smoke, and that is what she thought LPN #2 would be doing while she went to the West building to get another drug screen. The American Nursing Association Ethics			

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	web site at www.ana.org, indicated the following: The nurse delivers care in a manner that preserves and protects clients autonomy, dignity, and rights. The nurse seeks available resources to help formulate ethical decisions. The most current abuse policy provided by the Administrator on 2/23/11 at 10:30 A.M., indicated the following: Overview - The facility has implemented processes that include the seven components of abuse prevention and management: screening, training, prevention, identification, protection, investigation, and reporting... Prevention - 1.) Ensure that prevention techniques are implemented in the facility including, but not limited to : Ongoing supervision of employees through visual observation of care delivery... 2.) Identify, correct, and intervene in situations where abuse, neglect, and/or mistreatment are most likely to occur... Protection - 1.) Provide for the immediate safety of the resident/patient upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property.... This federal tag is related to Complaint IN00085926. 3.1-35(g)(1)			

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